COORDINATION OF BENEFITS WORKSHEET

If you, or any of your dependents who are covered under any State of Illinois health plan, are covered under any other health plan(s), you must provide this information to your Group Insurance Representative to ensure health claims are correctly processed (examples include non-state group health plans, Medicare and Medicaid).

You must complete Section A and Section C below. If you have other insurance, you must also complete Section B **and** provide a copy of the insurance identification card from the other coverage. You must return the completed COB Worksheet to your Group Insurance Representative/Preparer.

SECTION A

Member Name: _____ Social Security #: _____

☐ I and/or my dependents do NOT have other group health insurance coverage.

☐ I and/or my dependents DO have other group health insurance coverage (you must complete Section B indicating the other coverage). **YOU MUST COMPLETE A SEPARATE FORM FOR EACH INSURANCE COMPANY.**

SECTION B

Insurance Company Name: _____

Policy Holder Name: _____

Identification Number: _____ Group Number: _____

Effective Date: _____ Policy Type: Medical _____ Dental _____

Covered Persons	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

SECTION C

It is my responsibility to ensure that accurate information is maintained and kept updated regarding my other health/dental insurance. If other coverage is added or terminated for any individuals covered under my State Employees' Group Insurance Program, I must notify the Group Insurance Representative immediately.

I certify the above information is accurate.

Member Signature: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY TO EXPEDITE CLAIM PROCESSING.